

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018159

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 651 STATE FILE NUMBERVS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF
CERTIFICATION
Scott C. Benson, M.D.

FILED JUN 11 1962

1. PLACE OF DEATH
a. COUNTY Buchananb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. JosephLength of stay in 1b
49yrsc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION St. Joseph HospitalInside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Buchanan

c. CITY OR TOWN St. Joseph,

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
410 VirginiaReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First Louis

Middle F

Last Urbaniak

4. DATE OF DEATH

Month June 3, 1962 Year

5. SEX
Male6. COLOR OR RACE
White7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐8. DATE OF BIRTH
Aug. 26, 19129. AGE (last birthday)
49IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer10b. KIND OF BUSINESS OR INDUSTRY
Farm11. BIRTHPLACE (City and state or country)
St. Joseph Mo12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

William Urbaniak

13b. MOTHER'S MAIDEN NAME

Cecelia Pyzora

14. NAME OF HUSBAND OR WIFE

none

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT Address
Cecelia Urbaniak, St. Joseph, Mo

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage
Hypertensive C. Disease

INTERVAL BETWEEN ONSET AND DEATH

12h.

10 yrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT SUICIDE HOMICIDE
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 6/2 to 6/3/62 and last saw her alive on 6/2/62.
Death occurred at 2:00A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

(Licensed Embalmer's Statement on Reverse Side)

JUN 19 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

~~on~~ by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John E. Rupp

Licensed Embalmer No. 3986

P. O. Address

St. Joseph Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.